VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
A VALUEOPTIONS® COMPANY

Residential Treatment Facilities
VBH-PA Performance Standards

Overview: As defined by the Office of Mental Health and Substance Abuse Services (OMHSAS), residential treatment facilities (RTF) are childcare facilities that are licensed under Chapter 3800 of 55 P A Code and certified by OMHSAS. Residential Treatment Facilities provide 24-hour living arrangements and mental health treatment for children and adolescents whose needs are such that they can only be served in a 24-hour residential setting.

Residential Treatment Facilities provide treatment within the continuum of psychiatric and therapeutic interventions, intended for children and adolescents whose psychiatric symptoms cannot be addressed through services delivered in the community. Services at this level of care are intended to address the intensive treatment needs of children and adolescents. An RTF provides a setting in which a child or adolescent is expected to receive intensive reassessment, re-training, and skill-building opportunities. RTFs also offer the opportunity for the optimization of a psychotropic regime, when psychotropic intervention is an integral part of a child's treatment. Treatment approaches are designed to address the specific psychiatric symptoms of the child, and to build resiliency of the child and family. Education and empowering the child and family are key to the child's successful return to the community and should be integral to the RTF treatment practices.

The goal of this document is to develop standards and outline best practice guidelines for treatment of children in Residential Treatment Facilities. These standards are intended to clarify expectations and define the parameters of reasonable practice for the provision of residential treatment. Overall, this document is reflective of the current level of quality within the network and the commitment of all stakeholders to continually strive to improve the quality of residential treatment services.

These standards are intended to support, not replace, licensing, accrediting and credentialing regulations in the state of Pennsylvania. In some instances, the standards exceed baseline licensure requirements.

Definitions: To improve the readability of the document, "child" or "children" is the term that will refer to an individual less than 21 years of age.

"Family" refers to parent(s), stepparent(s), caregiver(s), legal guardian(s) or custodian(s), foster parent(s), adoptive parent(s), siblings, half siblings, and others as deemed appropriate.

Residential Treatment Facility (RTF) indicates premises operated in a 24-hour living setting in which behavioral health treatment is provided for one or more children with diagnosed mental illness, serious emotional or behavioral disorders, or a substance abuse condition in conjunction with mental illness.

Program design: Residential Treatment Facilities offer short term to intermediate term intensive treatment programs, intended to help the child recover from mental illness and to promote successful return of the child to the community. A written program description must guide the RTF operations and delivery of services. This description should identify the core clinical orientation of the program, as evidenced in program policies and procedures. The staff training curriculum should also reflect this core clinical orientation. Regardless of the clinical orientation, best practice services are designed to be trauma informed, evidence based and recovery focused:

- Trauma informed: The RTF makes continuous effort to develop and sustain a trauma informed culture, in which the structures, processes and staff interactions are intended to facilitate healing and growth. The culture reflects non violence, shared governance, open communication, respect and responsibility. Skill building toward affect management and self regulation is built into daily activities. The organizational structure and policies reflect commitment to this culture at every level.

- Evidence Based: Interventions are to reflect current evidence based practice at all times. The RTF is to be committed to incorporating best practices through ongoing skills training, staff supervision and quality improvement.

- Recovery Focused: The program will support children and families in achieving their potential for functioning. Recovery principles will be reflected in a program focus on hope, maximizing strengths, self-determination, development of coping strategies and supportive relationships.

The program will identify the ways in which children with multiple disorders or disabilities will be accommodated in treatment. The program will also outline the process for partnering with outside treatment providers when needed to address special treatment needs, such as substance abuse and physical health care providers.

Treatment Program: The following highlight the general expectations on what program activities are routinely provided in residential treatment facilities. RTF programs are expected to incorporate:

- Therapeutic Milieu: Milieu therapy is an integral part of the daily program at residential treatment facilities. The therapeutic environment provides regular opportunities for both treatment and therapeutic activities.
- Individual Therapy: Every child is expected to be provided with the opportunity for weekly scheduled one-on-one interaction with a master's level clinician, and spontaneous individual therapy as opportunities for intervention arise. Individual therapy is expected to be included in the treatment plan for every RTF resident. Providers will document clinical reasons for any deviations from this performance standard.
- Family Therapy: Each child is expected to participate in a family-focused therapy session on at least a weekly basis. Community-based family sessions closer to the families home are encouraged. Contact with the family (for example, to update them about the child's status) is not a substitute for family therapy on a weekly basis. If a less intense schedule for family therapy is developed with the family, the provider is expected to document that decision and the reasons for the less intense family treatment plan.
- Group Therapies: Group therapy is a core component to daily programming. Core psycho-

educational group topics will be identified; eg: Anger Management, Self-awareness, Social Skill Development, Developing Positive Relationships with Peers and Family, Conflict Resolution, and Anxiety Management. Specialized groups to address issues such as substance abuse and sexual abuse are offered as needed. If specialized groups are unavailable at the RTF yet needed, the RTF provider will arrange for children to receive such services outside of the RTF setting. Traditional process groups to review progress on daily/weekly goals are also an expected therapeutic intervention.

- Visitation: The child and family, including siblings, should have contact with one another unless deemed counter therapeutic. Frequent, ongoing and meaningful child and family contact is an agency priority that is fully and flexibly supported by agency practices. Child and family visits or telephone calls are not cancelled or abbreviated as a result of child behavior, or used as a privilege or consequence. If a child is having behavioral difficulties, increasing the frequency of visits may be considered if the family is able.
- Therapeutic Leaves: Therapeutic leaves are viewed as a furtherance of treatment, not as a consequence or privilege. They are prescribed by the psychiatrist based upon mental health stability, and the ability to be safe during the therapeutic leave. Providers are expected to maintain documentation of the physician's order for the therapeutic leave, a description of the desired outcome, the date and time of the leave, and a written evaluation resulting from interviews with both the child and family or guardian after the leave period. Plans for therapeutic leaves are to be individualized, as reflected by observing flexible use of this intervention across residents in terms of days, hours. (Note: therapeutic leave is not limited to overnight visits, but includes planned day therapeutic visits). Providers are expected to document educational efforts with families to emphasize the therapeutic goals of leave time and the importance of not creating a "holiday" environment that excludes work toward goals. The RTF provider maintains clinical responsibility for residents while on leave.
- Skill building opportunities within the RTF and community settings: Residents are to be provided with opportunities to practice skills being developed in formal groups and therapy in natural informal settings.
- Opportunities for community participation on at least a weekly basis are provided.
- Regular contact with the Interagency Team: RTF providers share monthly updates with members of the interagency team.
- Medication administration and monitoring on a daily basis and at least monthly monitoring by a psychiatrist.

The RTF must establish a policy for the use of restrictive safety procedures.

- Seclusion is prohibited in RTF in the state of Pennsylvania. Seclusion is defined as anything that prohibits a child's egress from a room.
- Use of physical restraint is only permitted for emergency safety situations, defined as unanticipated child behavior that places the child or others at threat of violence or injury if no intervention occurs.
- The use of restraint is only to occur when less restrictive interventions are not effective to protect the child or others.
- The policy must address the following:
  - Use of a restrictive plan only when less restrictive methods have been ineffective, and only in case of ongoing serious safety threat
  - Requirement of an order for restraint

- Immediate physician notification when restraint occurs
- Assessment of the child during and after restraint
- Notification of the child's parents regarding incident
- Modification of the child's safety/crisis plan to address alternatives to restraint
- Staff debriefing
- Resident debriefing

Cultural Competence and Sensitivity: Agency wide cultural competence is a fundamental requirement in creating a therapeutic treatment environment. The RTF is expected to recognize and work within the cultural viewpoints of community populations including, but not limited to:

- Deaf and hard-of-hearing, and children of deaf adults (CODA)
- Sexual Minorities
- Specific religious groups, including Jewish, Muslim, Christian, Hindu faiths
- Rural Americans
- Military personnel and their families
- Racial and ethnic minorities

All RTF providers are expected to support the development of cultural competence within their programs through:

- Ongoing staff training to ensure that all children and families receive from all staff members effective, understandable and respectful service that is provided in a manner compatible with their cultural beliefs and practices.
- Open, respectful communication with children, families and caregivers about their culturally based values and beliefs.
- Respecting the wishes of families in the celebration of holidays, special social activities, and gift giving.
- Making available easily understood consumer related materials and posting signs in the languages of the commonly represented groups in the service area.
- Ensuring that conflict and grievance resolution processes are culturally sensitive.
- Implementation of strategies to recruit, retain and promote, at all levels of the organization, a diverse staff and leadership that are representative of the people they serve.
- Ensuring that the physical facility is ADA compliant when possible, or provide accommodations as needed.
- Ensuring that processes are in place to obtain translation services for non-English speaking persons and hard-of-hearing or deaf persons. The RTF should explore creative options to maximize communication in these instances, such as the use of email for deaf and hard of hearing families. The RTF should minimize reliance upon family members to provide translation.
- Providing assistance to visually impaired children and family members to allow participation in programming.

Providers are expected to maintain documentation of all initiatives and interventions to further develop the cultural competence and sensitivity of staff, and interventions to improve the overall cultural competence their programs. The RTF is expected to assess the cultural competence of its programs through tracking and monitoring member complaints.

Staff Qualifications, Staffing and Training

Staffing: At all times the RTF will meet minimal standards for staffing as defined in the Chapter 3800 regulations of 55 PA Code, and their own accepted program description and policies.

The staff to patient ratio will be increased as needed to take into account the needs of specialized populations, as well as providing safety for specific clinical or programmatic requirements. Depending upon the needs of the child, consideration will be given to providing same gendered staff as well as more than one staff at a time, for the protection of both children and staff.

Physician role and responsibilities: The RTF staff must include a psychiatrist or medical consultant experienced in the delivery of Child and Adolescent mental health services, who minimally provides the following services:

- Has training and/or specific experience in treating children and adolescents with mental health service needs
- Coordinates and advises the program leadership on clinical matters
- Functions as the clinical lead in each patient's treatment team.
- Regular and ongoing contact with treatment staff to assist with treatment plan development, implementation and monitoring. Psychiatrists are expected to be present and active participants in the interagency team meetings and treatment team meetings.
- Prescribes and regulates medication as indicated.
- Provides direction and consultation on a regular basis.
- Has regular and ongoing face to face or phone contact with each child' family. Psychiatrists are expected to provide psycho-education, especially regarding diagnostic implications and psychotropic interventions, to members and families.
- Provides regular ongoing evaluation and treatment of each resident. The psychiatrist must evaluate each resident within the first 7 days after admission. The psychiatrist must then see each resident face to face as deemed clinically necessary, but not less frequently than every 30 days.

Staff training: Program staff will have credentials, experience and ongoing training relevant to the mental health service needs for children and their families. At a minimum, staff training will meet minimal standards for staffing as defined in the Chapter 3800 regulations of 55 P A Code.

Prior to working alone with children, each direct care staff person will have at least 30 hours of orientation training to include:

- Cultural Competency
- Fire Safety
- CPR (repeated annually)
- first aid (repeated annually)

- Heimlich maneuver (repeated annually)
- Universal precautions
- Child Protective Services Law

Annually, each staff person will have 40 hours of continuing training on related subjects. Specific training to enhance the staff ability to address the clinical needs of the children and families is expected. RTFs with a particular treatment focus, such as Autism Spectrum Disorders, Developmental Disabilities, juvenile offenders, or sexually maladaptive behaviors, will have staff training programs reflecting adequate preparation of the staff for the population served.

All direct care staff will have completed training in the method of restrictive procedure used by the RTF within the past six months, or more frequently if required by the restrictive procedure training protocol.

Any staff person who is responsible to lead activities of a high risk nature, such as swimming, horseback riding or climbing, will be trained in safe practices regarding these activities. Relevant certifications (such as lifeguarding) are required if applicable.

Documentation of all staff training will be kept by the RTF administration.

Clinical Supervision: Clinical supervision is an essential practice to ensure the welfare of the patient through the use of ethical and clinically sound practices, as well as to develop therapeutic competence in the clinician. Clinical supervision is separate from administrative management, staff meetings or case staffing. All staff providing individual, group or family therapy will receive supervision from an experienced and qualified clinician. Each facility will have a written policy for clinical supervision, delineating the frequency, modality and documentation of supervision.

Information coming out of clinical supervision will be shared with other team members as relevant through case consultation, treatment team meetings and other venues.

Medication Training: Proper administration and oversight of medication (including all prescribed and over-the-counter oral, topical, injected, eye and ear drop medications) is essential to the health and safety of RTF residents. All RTF facilities will follow the Pennsylvania DPW Medication Administration Model as the policy and procedure for medication administration.

Only staff members trained using the Pennsylvania DPW Medication Administration Model will be permitted to administer medication. Facilities may elect to send staff members for higher level training to become "trainers" within their facility. Additional training is required for staff persons without a medical or nursing license who will be administering insulin or other diabetic interventions to residents.

Each RTF will have a policy outlining medication storage, accountability and administration, including the disposal of unused medication and self-administration of medication by residents.

Access Standards: Relevant, up to date, clinical information is necessary for sound decision making regarding admission to Residential Treatment Facilities. While a Psychiatric Evaluation can provide information up to 60 days, all efforts should be made to secure current information for admission.

Several standards *were* identified to expedite access:

- RTF providers are expected to respond to referral sources as to action they have taken upon receipt of a referral, on at least a weekly basis, in order to facilitate timely access to care.
- RTF providers are expected to inform referral sources as to their current "skill sets", identifying program strengths and the profiles of children they can most effectively serve.
- Each RTF provider is expected to review and update the current service description whenever programmatic changes occur. Updated service descriptions must be distributed to stakeholders (including BH-MCOs and families as requested).
- Updated service descriptions are to include the following elements:
    - Treatment specializations offered by the facility
    - Description of the primary treatment models of the facility
    - Policy regarding transportation
    - Frequency and type of treatment interventions
    - Frequency of family work
    - Education capacity: Identify how the facility ensures that the educational needs of its residents are met.
    - Information about whether home-based services are a typical part of the treatment approach of the facility
    - Special populations that the facility is equipped to treat

- RTF providers are expected to decline referrals of children for whom they cannot provide appropriate treatment or safety. Alternative recommendations to more clinically appropriate setting are made for those children who are not accepted for admission.

Components of Family Involvement: Effective residential treatment is characterized by a number of program components, which contribute to successful treatment outcomes. Perhaps the most significant of these is meaningful family involvement. A commitment to family involvement recognizes that, more often than not, a youth arrives at an RTF as an identified member of a family and will return to that family upon discharge.

An RTF shall ensure that a child's family is given every opportunity to participate fully in the treatment process. The RTF will demonstrate a philosophy of respect and regard for the parent role. The culture of the RTF will reflect a high value on family partnership throughout the process. The culture will be demonstrated through non-blaming, welcoming and hopeful encounters, in which the strengths of the family and child are respected and drive treatment planning.

There are a variety of reasons why at first attempt, children or families may appear to be uninterested in participating in treatment. However, providers are expected to repeatedly try a variety of interventions to engage children and families in treatment and to document all efforts. Providers are expected to be creative and flexible in all outreach to families. Outreach efforts will reflect cultural sensitivity and respect.

The following represents a sample list of interventions that RTF providers are expected to employ to engage children and families to the fullest extent possible throughout the treatment process:

- Beginning the engagement process as early in the referral process as possible, typically prior to admission. Whenever possible, the child and family should be offered a tour of the RTF, given the opportunity to interview RTF staff and provided educational literature and/or web based information to reduce anxiety related to out of home treatment.

- Offering telephonic therapy sessions to accommodate families. When families are unable to attend family sessions at the RTF, for whatever reason, RTF providers are expected to offer participation in family sessions by phone as one way of maintaining involvement while obstacles to face-to-face sessions are being addressed.

- Offering video conferencing when possible to enhance communication with the psychiatrist, therapy staff and treatment team.

- Offering on line communication when possible.

- Offering family sessions in the family home as opposed to requiring the family to come to the RTF. Providers are encouraged to outreach to families in this manner when unable to resolve obstacles that prevent families from being able to participate in family sessions at the RTF. If a family has been unable to attend scheduled meetings at the RTF for a two-month period, the RTF provider is expected to offer to go to the family home for a session. If this offer is not made, reasons why must be clearly documented.

- Reviewing and modifying treatment goals with the family on a monthly basis to ensure that the goals accurately reflect the family's goals.

- Making multiple attempts to reschedule appointments cancelled by families: one attempt to reschedule is inadequate. The RTF provider is expected to attempt to resolve any identified obstacles to family participation and to document such efforts.

- Maintaining general "family-friendly" communication standards as evidenced in program policies and procedures. Examples of "family-friendly" communication standards include providing families with easy access to treatment and program staff; encouraging contact between families and their children through phone calls, flexible family visits, and home passes; continually empowering families throughout the course of treatment to be critically involved in decisions and informed of events affecting their children. Providers are expected to document how families are informed about their access to program staff and invited to contact staff on a regular basis.

- Convening an interagency team meeting when engagement is unsuccessful or treatment appears to be stalemated.

- RTF providers are expected to maintain telephonic contact with members and their families if they require inpatient care during their residential treatment. This contact is necessary to

maintain continuity of care in the event that the child is returned to the RTF or to successfully transfer or transition the child to another provider or level of care.

- Exploring ways to resolve transportation barriers: In circumstances where families are challenged by transportation issues, the RTF will engage creatively with the family to explore community resources and partner when necessary to assist in transporting the child and/or family. An RTF, in partnership with community supports, will assist with the transportation needs of the child or family members in order to coordinate visits to home, and to facilitate family therapy sessions. Transportation as a support for transitions into other services or programs identified in the child's treatment plan is expected.

Additional Family Intervention:

- Orientation and education: Families should understand the types of treatment being provided, reasonable expectations for improvement and the family role in treatment. Education about the child's diagnosis and medication is an essential part of parent involvement and informed consent. In addition, assisting the family to access community resources and supports is key to helping them advocate for themselves and their child.
  The orientation is to include an open discussion about the importance of family participation in assisting children to achieve their goals. Providers are expected to document orientation activities or interventions.

- Offering parent support groups are highly desirable when possible.

- Family Therapy: The family and child should be actively involved in developing their child's treatment plan. Each child is expected to participate in a family-focused therapy session on at least a once weekly basis. This therapy should be individualized and flexible to address the presenting issues. Different members of the family should be included in family therapy sessions as clinically appropriate. The family should also be actively involved in the plan for transition and return to the community. If the family is unable to attend, the reasons for this will be documented.

- Decisions of daily living: Families should have regular and meaningful roles in key decisions regarding their child's care, including haircuts, activities and school needs. The family will be notified of any changes in the child's schedule or condition, and permission will be obtained from the parents for activities that are not in the normal daily routine.

- Consideration of mental health needs for all family members is documented in the treatment plan: These issues should be addressed when possible during family therapy session or in ongoing family contact with the RTF family therapist in order to attempt to ensure a successful reintegration for the child back into the family system.

- Families, natural supports, and other education and service providers are actively engaged in providing historic and present data regarding the child to include all past treatment episodes and responses. This input is encouraged throughout the child's admission.

Assessment following Admission to an RTF:
RTF providers are expected to:

- Assess the child the day of admission to the RTF, including initial psychiatric, psychosocial and general health assessments, and development of a safety plan. (Within the following weeks, additional assessment as clinically indicated will continue.)
- Continue assessing the child and making the appropriate additions/revisions to the comprehensive, individualized treatment plan during the first month of treatment.
- Meet within the first 30 days of treatment with the treatment team, including the child and family, to thoroughly develop and review the treatment plan and revise as necessary. Maintain documentation of treatment team meetings and revisions to the treatment plan.
- Hold an interagency team meeting approximately 45 days prior to the expiration of the current authorized service period to review progress toward goals, responsiveness to residential treatment, and to clinically evaluate the need for this level of care.

Health Assessment: A health and safety assessment must be completed within 24-hours of admission to the RTF and at least annually thereafter. If risks are identified during this assessment, then a plan must be developed and implementation begins within 24-hours. A complete physical health examination must be completed within 15-days of admission unless one has been done within 15-days prior to admission. The elements of the examination are contained within the regulations. Complete examinations ideally include assessment and treatment of physical, dental, vision and hearing health issues. Documentation includes plans to treat or if treatment is to be deferred, the rationale and time frame, of needs identified in any of these areas,

Access to medical care, both preventive and emergency, is addressed in policy and procedure. Healthy living practices are modeled, taught and encouraged to include basic hygiene, effective hand-washing, wholesome nutrition, daily exercise and avoidance of drugs, alcohol and tobacco products.

Elements of the Treatment Plan/ISP and the Service Planning Process: Every effort is to be made to include other involved services and systems throughout the assessment and treatment process. Input is to be sought from the educational system, extended family, supportive community members, juvenile probation services (when applicable), child protective services (when applicable), and any others identified by the child and family as a resource.

Key elements to the successful development of an individualized treatment plan or ISP (Individualized Service Plan) are also identified under the topic of service planning elements. A standardized "service plan" template will be utilized in all VBH-PA managed counties.

The treatment plan or ISP and the service planning process are expected to:

- Be recovery focused
- Be developed collaboratively, with the child and the child's family participating to the fullest extent possible.
- Link to the assessment of strengths and needs by life domains, and to identify the initial priorities for services.
- View the treatment plan/ISP as a flexible working document, changing as needed to reflect the child's current treatment needs.

- Identify an anticipated length of stay. The treatment team is to anticipate discharge placement, identify possible barriers to discharge, and include preparations for transition throughout the course of treatment. RTF is a temporary treatment program as opposed to a long-term placement option.
- Include and document discussions of discharge planning in the initial service planning process and on an ongoing basis.
- Identify how services from several sources will be coordinated and integrated to best address the needs of the child and family.
- Develop individualized crisis plan/relapse plans for the following situations:
- *Potential crises internal to the RTF*. For example, for residents for whom absconding is common, the RTF provider is expected to develop a proactive plan of action that ensures the resident's safety to the greatest extent possible in the event of this crisis.
- *Comprehensive safety plan for therapeutic leaves.* This will include the goals, expected outcomes, and an acknowledgment and processing of the family's concerns related to scheduling visits based on past or current safely concerns. It will also include crisis plan steps and contact telephone numbers. In preparation for therapeutic leaves, the provider reviews the child's crisis or relapse prevention plan with the child and family.
- *Modified plans when incidents occur indicating a safety risk.* For example, when self-injurious behavior occurs on the RTF unit, the crisis plan reflects environmental safety measures and specific therapeutic responses.
- A crisis/relapse plan addresses, at a minimum;
    - identification of prior precipitants to crises,
    - delineation of interventions to address precipitants,
    - a means of assessing the outcome of the interventions,
    - specific alternatives to be tried prior to consideration of inpatient treatment (given that the situation can be safely managed in current level of care),
    - plan for communicating significant events, in the child's life to members of the treatment team and
    - a plan for a debriefing after the crisis for the child, family, and staff as soon as possible but within forty-eight hours of the incidents.

- Identify how the child's educational needs will be met. The service plan needs to be well coordinated and integrated with a child's local or home school district. Whenever possible given the child's mental health status, the child will attend the local public school for better educational opportunities. The RTF will work to establish relationships with local school districts toward this end. The plan will address transitional issues and continuity of care issues between approved private schools, public schools and on-campus RTF-based schools. Release of information forms will be on record for all school contacts.
- Be individualized, despite the fact that there are some "core" treatment components to residential treatment.
- Identify specific, measurable goals and objectives. The goals need to reflect the strengths/needs, diagnosis, overall level of functioning, and priorities identified throughout the assessment process.
- Include activities that promote community-based integration and utilization of natural supports.
- Include family involvement in the treatment process to the greatest extent possible. It is expected that family goals be included in each child's treatment plan where appropriate.

- Include skill development goals.
- Consider new assessment information from psychiatric/psychological reevaluations required by regulations.
- Include psychiatric follow-up and medication management interventions.
- Include a monthly progress report and an update of the ISP with each continued stay request packet.
- Include use of standardized tool(s) to measure changes in overall levels of functioning throughout the course of treatment such as the CAFAS, Ohio Scales or CBCL.

Discharge/Return to the Community Plan: The goal of Residential Treatment is to prepare the child for the return to the community in the most family-centered or natural setting possible. However, the transition back to the child's home and community has many challenges due to stressors within the child's relationships which are compounded by disruption from the course of residential treatment. It is critical that the process of discharge planning begin upon admission and continue throughout the entire course of treatment.

The family is supported in being actively involved in the development of the plan for return to the community (or a transition plan for the child if placement/ permanency goals and/or court directives otherwise define discharge goals.) The Discharge/Return to the Community Plan identifies the family's strengths, needs and cultural values previously identified in the family involvement and treatment plans, supports needed by the child and family after discharge from the Residential Treatment Facility and living arrangements of the child after the residential stay is complete.

In collaboration with the interagency team, Residential Treatment Facilities are expected to

- Prioritize family involvement in discharge and transition planning using a spectrum of practices including family therapy, parent skills training and family support groups. The family is an equal and expert partner in the treatment and discharge planning processes.

- Educate and communicate to families and other supports about the shared responsibilities involved in discharge planning. Other involved child-serving systems are invited to remain actively involved with the child and family while receiving residential treatment.

- Identify and address barriers to discharge at the onset of treatment.

- Develop realistic goals for completion prior to discharge, in collaboration with the interagency team, and include the discharge criteria on the treatment plan or ISP. Residential treatment is not intended to "fix the child", but rather is an intervention intended to stabilize the child and promote successful community reintegration.

- Define interventions that work for a child, and ensure that this information is integrated into the discharge plan. Educate families or caregivers about what interventions have proven to be most helpful to a child.

- Ensure that therapeutic leaves/ home passes occur early in the treatment process. They are not to be approved or cancelled based upon behavior, but viewed as opportunities to further

treatment and transfer skills from the Residential Treatment Facility to the child's home, school and or community.

- Help families or caregivers anticipate and respond to behaviors likely to occur during discharge transitions (i.e. honeymooning, anxiety, ambivalence, limit testing).

Discharge Planning includes all of the following components:

1. Discharge planning Interagency Service Planning Team meetings within 45 days of a planned discharge date.
2. Identification of an agency to serve as clinical lead following discharge, no later than 45 days prior to discharge.
3. Identification of legal guardianship and post discharge residential arrangements.
4. Identification of triggers for relapse and a relapse prevention plan.
5. Identification of family supports.
6. The Residential Treatment Facility ensures that initial appointments for all follow-up services, including Psychiatric Medication management, are in place prior to discharge. The first therapy appointment is expected to be scheduled for no more than 7 days following the discharge date.
7. Arrangements for appropriate educational placement.
8. Initiation of follow-up services 30 days prior to discharge when possible.
9. Follow-up Practices:
    - Send written discharge summaries to all involved systems within 7 days of discharge.
    - Monitor the implementation of the discharge plan by following up with the child/family or caregiver by phone at approximately 15 days and then one month after discharge.
    - Contact the lead agency to address any concerns if the discharge plan is not being implemented as planned by the interagency team.
    - Be available for consultation with the interagency team to share knowledge about interventions and practices that have been helpful to the child in the past and to assist the team in addressing any problems the child may be experiencing post discharge.
    - In situations in which discharge is being considered because an RTF determines that it is unable to successfully address the needs of a resident, the RTF provider will convene an interagency team meeting to openly address this issue, determine if individualized program modifications may enable the resident to continue in treatment, or discuss and formulate alternative treatment options.

Outcome and Quality Indicators: RTF providers will address all current quality measurements required by the state, counties and MCO.

In addition, all RTF providers are expected to have an outcomes measurement plan that is directly related to the overall quality improvement plan for their facility.

Providers will be expected to share the program outcomes measurement plan during regularly scheduled quality audits by the BH-MCO.

The outcomes measurement plan will:

- Evolve from asking questions such as "Who did we serve," "What services were provided," and "What were the results." The plan should produce useful, actionable data that provides the necessary feedback loop to continually improve the overall quality of care.
- Collect data on standard issues over intervals of time (such as admissions, discharge, and post discharge).
- Identify the specific outcome indicators to be measured, to include a combination of process indicators (i.e., costs, demographics, length of stay, # of hospitalizations), functional indicators (i.e., educational status, school attendance, restrictiveness of living environment), clinical indicators (i.e., symptom reduction, CAFAS), and satisfaction measures.
- The following list of outcome indicators pertinent to residential treatment was identified. This is intended to be a sample of outcome indicators. Each facility is expected to design an outcomes measurement plan that serves their overall program goals and agency mission. RTF providers are not expected to include every indicator listed in their outcomes measurement plan, but must include at a minimum at least one functional indicator, clinical indicator, and satisfaction measure.

Examples of Process indicators:

1. Length of stay
2. Number of parent contacts by RTF provider during treatment
3. AMA discharge rates
4. AWOL rates

Examples of Functional indicators:

1. Restrictiveness of educational placement
2. Restrictiveness of living environment
3. Stability of living environment
4. Post discharge level of care
5. Inpatient recidivism
6. Child-serving systems involvement following discharge
7. Community involvement following discharge

Examples of Clinical indicators:

1. Standardized symptom measurement tools
2. Safety assessment post-discharge and extent of engagement in at-risk behaviors
3. Regularity of job or school attendance post discharge

Satisfaction Measures: All RTF providers are expected to assess child and family satisfaction on a routine basis.

- Satisfaction is to be measured at admission (satisfaction with intake and admission process), during the stay (satisfaction with treatment, accessibility, communication, implementation of CASSP principles, facility, food, staff interaction), and post discharge (supported through transition, adequate discharge planning and implementation of the plan).
- Results of the satisfaction measures are to be incorporated into program's continuous quality improvement efforts.